Dementia Diagnosis Rates – CCG ambition template

Our ambition is to

- know everyone living with dementia in XX
- to ensure all people with probable dementia have been offered an opportunity to be given a diagnosis and discuss treatment options
- to ensure their carers have been offered support information and advice, regardless of whether the person they are caring for wishes to have a diagnosis and treatment

Objectives to achieve ambition:

Coding	**√**
Coding clean up exercise completed in all GP practices within the last year	
Memory service and other mental health service dementia register compared with GP practice QOF registers and disparities resolved (data harmonisation)	

Care Homes	**√**
Systematic review of all residents in all nursing and all residential care homes completed to ensure no missed diagnoses. DiADeM is a useful tool for GP led diagnosis	
Steps put in place to prevent further missed diagnoses e.g. DeAR-GP rolled out, protocols/pathways for assessment of new residents for cognitive disorders and diagnosis/treatment if appropriate	

Physical Health Conditions	**√**
When someone receives a diagnosis outside the memory assessment services, a clear letter is sent to the GP with the diagnosis, the patient is coded on the system and is able to access post diagnostic support *Neurology clinics, geriatrician clinics, Parkinson's clinic, falls clinic, learning disabilities etc.*	
Staff working in services managing patients who have a high risk of having dementia e.g. diabetes clinics, community stroke services have the confidence and competence to pick up concerns relayed by patients and carers, and to be supported by a clear referral process to the memory service	
Ensuring that patients with delirium in hospital clear have this document on DC summary to enable primary follow up to see if dementia assessment is required	

Memory Service	**√**
Memory services have reviewed opportunities for streamlining pathways and are working towards a 6 week referral to diagnosis and treatment time	
Memory service is monitored by the CCG including: • waiting times from referral to diagnosis and initial treatment plan • Diagnosis conversion rates (proportion of people in service who are diagnosed as having dementia on discharge) • Activity data • Patient and carer experience and satisfaction	

Mild Cognitive Impairment	**√**
All patients with MCI on a register either in primary care or at memory service	
Mechanism in place for yearly review of people with MCI – until static cause determined, MCI resolved or diagnosed with dementia (primary and secondary care)	

Communities	**√**
Active and ongoing plan in place for engaging with minority groups to de stigmatise dementia. For example by working with faith leaders, community groups, schools etc.	